

# EMPLOYEE'S CERTIFICATION OF DEPENDENCY STATUS (DWC-04)

## General Instructions:

- Completed by: Employee.
- Time Frame: No set time frame. However, if the employee does not complete and forward this form to the claim administrator promptly, it may result in a delay of payment.
- Distribution: Original from employee to claim administrator or employer. Claim administrator must attach to appropriate documentation when filing with DLT.
- Attachments: None.

## Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

### 1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Male/Female:* Check one.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.
- *Date of Birth:* Date the employee was born.

### 2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Address (including city, state, zip):* Mailing address of the claim administrator.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).

### 3. Marital Status & Exemption Information:

- *Were you married at the time of your injury?:* Check correct box.
- *If Yes, Spouse Name:* First and last name of spouse.
- *If Yes, does your spouse work?:* Check correct box.
- *Spouse SSN:* Completion of the Social Security Number for the spouse is optional.
- *Please put an appropriate number in each box:* Exemption information is used by the claim administrator to calculate the weekly compensation amount. Failure to provide it may result in a delay of payment.
  - *Yourself:* The employee is automatically entitled to one exemption.
  - *Spouse:* Enter '1' in this box if employee is married.
  - *Total Dependents Listed Below:* Add up the number of dependents in Section 4 and put the total in this box.
  - *Total Other:* If employee is entitled to exemptions for over 65 and/or blind, enter number here.
  - *Total Number of Exemptions:* Add above numbers to get total number of exemptions.
- *Dependent's Name:* First and last name of each dependent.
- *Dependent's Date of Birth:* Date each dependent was born.
- *Dependent's Social Security Number:* Completion of the Social Security Number for the dependent is optional.
- *If over 18 and under 23, Full-Time Student?:* For each dependent over the age of 18 and under the age of 23, check box as to whether or not each one is a full-time student at an accredited educational facility.
- *Employee Signature/Date:* Signature of employee and date form was completed.